War Related Illness and Injury Study Center

HEALTH QUESTIONNAIRE

INSTRUCTIONS

Please complete this questionnaire as it will provide us with valuable information.

- Please complete this questionnaire as completely and accurately as possible.
- Please print legibly and use black ink.
- Please fill in the circle or box provided. Examples: ● ■
- If you make a mistake, put an "X" through the wrong answer. Example: ⊗

WRIISC
War Related Illness & Injury Study Center

PUBLIC HEALTH

VA HEALTH CARE
Defining EXCELLENCE in the 21st Century

Section 1: General Demographics

Please print legibly.

First Name: _____ Last Name: _____

SSN: ___ - __ - ____

Date of Birth: __ / __ / ____ (M M / D D / Y Y Y Y)

Sex (Fill in one answer): ○ Male ○ Female

Today's Date: __ / __ / ____ (M M / D D / Y Y Y Y)

Race (Fill in all that apply.):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown

☐ Other: _____

Ethnicity (Fill in one answer.): ○ Non Hispanic or Non Latino ○ Hispanic or Latino ○ Unknown

Education (Please fill in the *highest year* of school you completed. Fill in one answer.):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 +23

○ ○

Education (Please fill in all educational degrees obtained):

☐ High School diploma/GED ☐ Technical/Trade School ☐ Associate Degree ☐ Bachelor Degree

☐ Master's Degree ☐ PhD/Doctorate Degree ☐ MD ☐ JD

☐ Other: _____

Primary Language: _____

Secondary Language: _____

Marital Status (Fill in one answer.):

○ Currently Married ○ Widowed ○ Divorced ○ Separated ○ Never Married ○ Living with a Partner

Number of years with current partner or spouse: __

Number of times married: __

How is your partner's/spouse's health? (Fill in one answer.)

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

Employment Status (Fill in all that apply.):

☐ Employed Full-Time ☐ Employed Part-time ☐ Unemployed

☐ Student ☐ Homemaker ☐ Retired

☐ Applying for Disability Benefits ☐ Receiving Disability Benefits

☐ Other: _____

Are you right or left hand dominant? (Fill in one answer.)

○ Don't know ○ Right ○ Left ○ Both/Ambidextrous

Section 2: Military Demographics

Service Affiliation Dates: Please list start and separation dates for all military service:

SERVICE	MONTH/YEAR START	MONTH/YEAR END	SERVICE	MONTH/YEAR START	MONTH/YEAR END
Army	MM/YYYY	MM/YYYY	Air Force	MM/YYYY	MM/YYYY
Army Reserve	MM/YYYY	MM/YYYY	Air Force Reserve	MM/YYYY	MM/YYYY
Army National Guard	MM/YYYY	MM/YYYY	Air National Guard	MM/YYYY	MM/YYYY
Navy	MM/YYYY	MM/YYYY	Marine Corps	MM/YYYY	MM/YYYY
Navy Reserve	MM/YYYY	MM/YYYY	Marine Corps Reserve	MM/YYYY	MM/YYYY
Coast Guard	MM/YYYY	MM/YYYY	Coast Guard Reserve	MM/YYYY	MM/YYYY
Public Health	MM/YYYY	MM/YYYY	Other (_____)	MM/YYYY	MM/YYYY

Last Pay Grade (e.g., E5, O4, W3, etc.): _____

List all primary and secondary assigned occupations (e.g., NEC, MOS) for your military service:

TITLE/DESCRIPTION	MONTH/YEAR	TO	MONTH/YEAR
_____	MM/YYYY	to	MM/YYYY
_____	MM/YYYY	to	MM/YYYY
_____	MM/YYYY	to	MM/YYYY

Please state the name(s) of your Military Unit(s): _____

_____

Type of Military Unit (Fill in all that apply.): ☐ Combat Arms ☐ Combat Support ☐ Combat Service Support

Types of Military Areas Served (Fill in all that apply.):

☐ Combat zone ☐ Other land area ☐ Sea Duty ☐ Don't Know

☐ Other: _____

Military Discharge (Fill in one answer.): ○ Honorable ○ General ○ Dishonorable ○ Medical

Were you ever a Prisoner of War? (Fill in one answer.): ○ No ○ Yes

Please provide Dates, Location, and Job Duties for ALL deployments (Use the Key below for Conflict Code):

DEPLOYMENT		MONTH	YEAR	LOCATION(S)	CONFLICT CODE (See below)	MILITARY JOB DUTIES (If different from previous page)
#1	START	M M	Y Y Y Y			
	END	M M	Y Y Y Y			
#2	START	M M	Y Y Y Y			
	END	M M	Y Y Y Y			
#3	START	M M	Y Y Y Y			
	END	M M	Y Y Y Y			
#4	START	M M	Y Y Y Y			
	END	M M	Y Y Y Y			
#5	START	M M	Y Y Y Y			
	END	M M	Y Y Y Y			

CONFLICT CODES:

1 = WWII	2 = Korea	3 = Vietnam	4 = Lebanon	5 = Panama	6 = Grenada
7 = Operation Desert Storm/Desert Shield		8 = Kosovo	9 = Bosnia	10 = Croatia	11 = Somalia
12 = OEF	13 = OIF	14 = Operation New Dawn			

15 = Other: _____

Section 3: Health Concerns

1. Please list your top 3 most bothersome health concerns:

   1. _____

   2. _____

   3. _____

2. Please indicate how often you have experienced any of the following health conditions in the PAST 6 MONTHS (Fill in one answer for each health condition.):

	NEVER	ONCE A YEAR	ONCE A MONTH	ONCE A WEEK	TWICE A WEEK	EVERY DAY
Palpitations or heart pounding	○	○	○	○	○	○
Difficulty breathing (short of breath)	○	○	○	○	○	○
Wheezing	○	○	○	○	○	○
Headaches	○	○	○	○	○	○
Passing out and fainting	○	○	○	○	○	○
Paralysis	○	○	○	○	○	○
Muscle weakness	○	○	○	○	○	○
Difficulty with urination (passing water)	○	○	○	○	○	○
Blood in the urine	○	○	○	○	○	○
Genital sores/history of STD (VD)	○	○	○	○	○	○
Neck aches or pains	○	○	○	○	○	○
Arm, hand, foot, or leg aches and pains	○	○	○	○	○	○
Nausea or vomiting	○	○	○	○	○	○
Intestinal or stomach problem	○	○	○	○	○	○
Diarrhea	○	○	○	○	○	○
Gaining/losing > 15 pounds without effort	○	○	○	○	○	○
Excessive gas	○	○	○	○	○	○
Feeling hot or cold regardless of weather	○	○	○	○	○	○
Difficulty sleeping	○	○	○	○	○	○
Sensitivity to cold or heat	○	○	○	○	○	○
Skin trouble (rashes, boils, or itching)	○	○	○	○	○	○
Chest pains	○	○	○	○	○	○
Chronic cough	○	○	○	○	○	○
Dizziness	○	○	○	○	○	○
Numbness or tingling in any body part	○	○	○	○	○	○
Troubles or redness with eyes or vision	○	○	○	○	○	○
Trouble with the senses of taste and smell	○	○	○	○	○	○
Seizures (convulsions or fits)	○	○	○	○	○	○

b. Please indicate how often you have experienced any of the following health conditions in the PAST 6 MONTHS (Fill in one answer for each health condition):

	NEVER	ONCE A YEAR	ONCE A MONTH	ONCE A WEEK	TWICE A WEEK	EVERY DAY
Need to urinate at night	○	○	○	○	○	○
Erectile dysfunction/sexual activity problems	○	○	○	○	○	○
Back pain	○	○	○	○	○	○
Swelling of arms, hands, legs, or feet	○	○	○	○	○	○
Difficulty swallowing	○	○	○	○	○	○
Constipation	○	○	○	○	○	○
Poor appetite	○	○	○	○	○	○
Trouble with teeth	○	○	○	○	○	○
Black stool or blood in stool	○	○	○	○	○	○
Shakiness	○	○	○	○	○	○
Excessive perspiration	○	○	○	○	○	○
Fever/feeling feverish	○	○	○	○	○	○
Swollen glands or unusual lumps	○	○	○	○	○	○
Trouble concentrating or easily distracted	○	○	○	○	○	○
Forgetful or trouble remembering things	○	○	○	○	○	○
Hard to make up your mind or make decisions	○	○	○	○	○	○
Increased irritability	○	○	○	○	○	○
Taking more risks such as driving faster	○	○	○	○	○	○
Trouble with ears/hearing	○	○	○	○	○	○

3. Has your doctor ever told you that you have any of the following conditions? (Fill in all that apply.)

☐ High blood pressure	☐ Parkinson's disease
☐ Low blood pressure	☐ Poor circulation, varicose veins, or blood clots
☐ Heart murmur or mitral valve prolapse	☐ Seizures or epilepsy
☐ Angina, heart attack, or coronary heart diseases	☐ Migraines
☐ Arrhythmia or irregular heart beat	☐ Multiple sclerosis
☐ Peripheral neuropathy	☐ Emphysema or chronic lung disease
☐ Spinal cord injury	☐ Chronic bronchitis
☐ Asthma or reactive airway disease	☐ Silicosis or asbestosis
☐ Pneumonia or pleurisy (painful breathing)	☐ Chronic sinusitis
☐ Sleep apnea	☐ Benign prostatic hypertrophy (enlarged prostate)
☐ Allergies, nasal polyps, or hay fever	☐ Hearing loss
☐ Kidney or bladder stones	☐ Repeated kidney or bladder infections
☐ Arthritis or gout	☐ Chronic back pain, sciatica, or herniated disk
☐ Broken bones or joint surgery or back surgery	☐ HIV Positive test/AIDS
☐ Blood transfusions	☐ Sickle cell disease or trait
☐ Anemia or thalassemia	☐ Problems with blood clotting or bleeding
☐ Leukemia or lymphoma or Hodgkin's disease	☐ Malnutrition
☐ Hepatitis or liver disease or cirrhosis	☐ Ulcer or reflux or hiatal hernia
☐ Pancreatitis or colitis	☐ Gall bladder disease or stones
☐ Heat exhaustion or heat stroke or frostbite	☐ Irritable bowel syndrome
☐ Fibromyalgia	☐ Diabetes or high blood sugar
☐ Multiple Chemical Sensitivity	☐ Chronic fatigue syndrome
☐ Lupus or sarcoidosis	☐ Lyme's disease
☐ Depression	☐ Thyroid disease or goiter
☐ Schizophrenia	☐ Post-traumatic stress disorder
☐ Hives or allergic dermatitis	☐ Panic attacks or anxiety disorder
☐ Skin cancer other than melanoma	☐ Bipolar disorder
☐ Other cancer	☐ Alcohol abuse or alcoholism
☐ Congestive heart failure or fluid on the lungs	☐ Substance abuse
☐ Stroke or mini-stroke or Transient Ischemic Attack	☐ Attention deficit/hyperactivity disorder
☐ Dementia or Alzheimer's disease	☐ Learning disorder or dyslexia
☐ Cognitive disorder	☐ Psoriasis or eczema
☐ Brain Injury	☐ Melanoma
☐ Meningitis	☐ Temporomandibular joint disorder (TMJ)
☐ Huntington's disease	☐ Mononucleosis

☐ Other: _____

_____

_____

_____

4a. Have you (or your partner or spouse) had any problems with infertility, miscarriages, or still births? (Fill in one answer.)

○ No ○ Yes ○ Unknown

4b. Have any of your biological children been diagnosed with birth defects? (Fill in one answer.)

○ No ○ Yes ○ Unknown

5. Please list any surgeries you may have had during your lifetime:

SURGERY 1: _____

_____

SURGERY 2: _____

_____

SURGERY 3: _____

_____

SURGERY 4: _____

_____

SURGERY 5: _____

_____

6. Please list any hospitalizations you may have had during your lifetime:

HOSPITALIZATION 1: _____

_____

HOSPITALIZATION 2: _____

_____

HOSPITALIZATION 3: _____

_____

HOSPITALIZATION 4: _____

_____

HOSPITALIZATION 5: _____

_____

Section 4: Family Medical History

MOTHER:

1. Please tell us the current state of health of your biological mother (Fill in one answer.):

O Good O Poor O Deceased O Unknown

2. If you indicated your biological mother has died, please tell us her age at death and cause of death:

Age at death: ☐☐☐ Cause of Death: _____

3. Please list any past or present medical conditions for your biological mother:

_____

_____

FATHER:

4. Please tell us the current state of health of your biological father (Fill in one answer.):

O Good O Poor O Deceased O Unknown

5. If you indicated your biological father has died, please tell us his age at death and cause of death:

Age at death: ☐☐☐ Cause of Death: _____

6. Please list any past or present medical conditions for your biological father:

_____

_____

BROTHER(S):

7. Do you have any biological brothers? (Fill in one answer.) O No O Yes
If No, Skip these question and go to Question 11.

8. If you indicated you have biological brother(s), please tell us how many: ☐☐

9. Please list any past or present medical conditions for your biological brother(s):

_____

_____

10. If any of your brothers have died, please tell us the age at death and cause of death.

Age at death: ☐☐☐ Cause of Death: _____

SISTER(S):

11. Do you have any biological sisters? (Fill in one answer.) ○ No ○ Yes
    If No, Skip these question and go to Question 15.
12. If you indicated you have biological sister(s), please tell us how many: ☐☐
13. Please list any past or present medical conditions for your biological sister(s):

    _____

    _____
14. If any of your sisters have died, please tell us the age at death and cause of death.

    Age at death: ☐☐☐ Cause of Death: _____

CHILDREN:

15. Do you have any biological children? (Fill in one answer.) ○ No ○ Yes
    If No, Skip these question and go to Section 5.
16. If you indicated you have biological children, please tell us how many: Son(s): ☐☐ Daughter(s): ☐☐
17. Please list any past or present medical conditions for your biological children:

    _____

    _____
18. If any of your children have died, please tell us the age at death and cause of death.

    Age at death: ☐☐☐ Cause of Death: _____

Section 5: Medications

Are you allergic to any medications? (Fill in one answer.) ○ No ○ Yes

If you are allergic to any medications, please list the name of the medication and the reaction:

MEDICATION 1: _____ REACTION: _____

MEDICATION 2: _____ REACTION: _____

MEDICATION 3: _____ REACTION: _____

Are you currently taking any medications, drugs, food supplements, or over the counter medications? (Fill in one answer.)

○ No ○ Yes

If you are taking medications, please list medications you are presently taking:

MEDICATION 1: _____ DOSAGE: _____

MEDICATION 2: _____ DOSAGE: _____

MEDICATION 3: _____ DOSAGE: _____

MEDICATION 4: _____ DOSAGE: _____

MEDICATION 5: _____ DOSAGE: _____

Do you consider yourself dependent on any prescription drugs? (Fill in one answer.) ○ No ○ Yes

Section 6: General Health

1. In general, would you say your health is? (Fill in one answer.)

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Fill in one answer for each activity.)

ACTIVITY	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
a. **Vigorous activities** (such as running, lifting heavy objects, participating in strenuous sports?)	○	○	○
b. **Moderate activities** (such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?)	○	○	○
c. Lifting or carrying groceries?	○	○	○
d. Climbing **several** flights of stairs?	○	○	○
e. Climbing **one** flight of stairs?	○	○	○
f. Bending, kneeling, or stooping?	○	○	○
g. Walking **more than a mile**?	○	○	○
h. Walking **several blocks**?	○	○	○
i. Walking **one block**?	○	○	○
j. Bathing or dressing yourself?	○	○	○

3. **During the past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities *as a result of your physical health*? (Fill in one answer for each problem.)

	NO, NONE OF THE TIME	YES, A LITTLE OF THE TIME	YES, SOME OF THE TIME	YES, MOST OF THE TIME	YES, ALL OF THE TIME
a. Cut down the **amount of time** you spent on work or other activities	○	○	○	○	○
b. **Accomplished less** than you would like	○	○	○	○	○
c. Were limited in the **kind** of work or other activities	○	○	○	○	○
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	○	○	○	○	○

4. **During the past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities ***as a result of any emotional problems*** (such as feeling depressed or anxious)? (Fill in one answer for each problem.)

	NO, NONE OF THE TIME	YES, A LITTLE OF THE TIME	YES, SOME OF THE TIME	YES, MOST OF THE TIME	YES, ALL OF THE TIME
a. Cut down the **amount of time** you spent on work or other activities	○	○	○	○	○
b. **Accomplished less** than you would like	○	○	○	○	○
c. Didn't do work or other activities as **carefully** as usual	○	○	○	○	○

5. **During the past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups? (Fill in one answer.)

○ Not at all ○ Slightly ○ Moderately ○ Quite a bit ○ Extremely

6. How much bodily pain have you had **during the past 4 weeks**? (Fill in one answer.)

○ None ○ Very Mild ○ Mild ○ Moderate ○ Severe ○ Very Severe

7. **During the past 4 weeks,** how much did *pain* interfere with your normal work including both work outside the home and house work)? (Fill in one answer.)

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

8. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time **during the past 4 weeks**... (Fill in one answer for each item.)

ACTIVITY	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Did you feel **full of pep**?	○	○	○	○	○	○
b. Have you been a **very nervous person**?	○	○	○	○	○	○
c. Have you felt so down in the dumps that **nothing could cheer you up**?	○	○	○	○	○	○
d. Have you felt **calm and peaceful**?	○	○	○	○	○	○
e. Did you have a **lot of energy**?	○	○	○	○	○	○
f. Have you felt **downhearted and blue**?	○	○	○	○	○	○
g. Did you feel **worn out**?	○	○	○	○	○	○
h. Have you been a **happy person**?	○	○	○	○	○	○
i. Did you feel **tired**?	○	○	○	○	○	○

9. **During the past 4 weeks,** how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? (Fill in one answer.)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

10. Please choose the answer that best describe how ***true or false*** **each** of the following statements is for you. (Fill in one answer for each problem.)

	DEFINITELY TRUE	MOSTLY TRUE	NOT SURE	MOSTLY FALSE	DEFINITELY FALSE
a. I seem to get sick a little easier than other people	○	○	○	○	○
b. I am as healthy as anybody I know	○	○	○	○	○
c. I expect my health to get worse	○	○	○	○	○
d. My health is excellent	○	○	○	○	○

11. Now we'd like to ask you some questions about how your health may have changed. (Fill in one answer for each item.)

	MUCH BETTER	SOMEWHAT BETTER	ABOUT THE SAME	SOMEWHAT WORSE	MUCH WORSE
a. **Compared to one year ago**, how would you rate your *health in general* now?	○	○	○	○	○
b. **Compared to one year ago**, how would you rate your *physical health* in general now?	○	○	○	○	○
c. **Compared to one year ago**, how would you rate your *emotional problems now* (such as feeling anxious, depressed, or irritable)?	○	○	○	○	○

Section 7: Mental Health

1. In the **LAST 4 WEEKS**, have you had an anxiety attack- suddenly feeling fear or panic? (Fill in one answer.)

   ○ No ○ Yes

If you answered **NO** to the previous question, please skip to Question 6.
If you selected **YES**, please continue to answer the following questions:

2. Has this ever happened before? (Fill in one answer.)

   ○ No ○ Yes

3. Do some of these attacks come suddenly out of the blue - that is, in situations where you don't expect to be nervous or uncomfortable? (Fill in one answer.)

   ○ No ○ Yes

4. Do these attacks bother you a lot or are you worried about having another attack? (Fill in one answer.)

   ○ No ○ Yes

5. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? (Fill in one answer.)

   ○ No ○ Yes

6. Over the **LAST 4 WEEKS**, how often have you been bothered by feeling nervous, anxious, on edge, or worrying about a lot of different things? (Fill in one answer.)

   ○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

7. What are the most stressful things in your life right now?:

For the next 4 questions, please answer the following:

Have you ever had any experience that was so frightening, horrible, or upsetting that in the **PAST MONTH** you:
(Fill in one answer for each item.)

	NO	YES
8. Had nightmares about it or thought about it when you did not want to?	○	○
9. Have tried hard not to think about it or went out of your way to avoid situations that remind you of it?	○	○
10. Were constantly on guard, watchful, or easily startled?	○	○
11. Felt numb or detached from others, activities, or your surroundings?	○	○

12. During the **PAST 2 WEEKS**, how often have you been bothered by the following problems?
(Fill in one answer for each item.)

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF OF THE DAYS	NEARLY EVERY DAY
a. Little interest or pleasure in doing things?	○	○	○	○
b. Feeling down, depressed, or hopeless?	○	○	○	○
c. Trouble falling asleep or staying asleep or sleeping too much?	○	○	○	○
d. Feeling tired or having little energy?	○	○	○	○
e. Poor appetite or overeating?	○	○	○	○
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down?	○	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television?	○	○	○	○
h. Moving or speaking so slowly that other people could have noticed OR the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	○	○	○	○

Section 8: Stress

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and *fill in one circle* that indicates how much you have been bothered by that problem in the past month.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
Repeated, disturbing *memories*, *thoughts*, or *images* of a stressful experience from the past?	○	○	○	○	○
Repeated disturbing *dreams* of a stressful experience from the past?	○	○	○	○	○
Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	○	○	○	○	○
Feeling *very upset* when *something reminded* you of a stressful experience from the past?	○	○	○	○	○
Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	○	○	○	○	○
Avoid *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	○	○	○	○	○
Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?	○	○	○	○	○
Trouble *remembering important* parts of a stressful experience from the past?	○	○	○	○	○
Loss of interest in activities that you used to enjoy?	○	○	○	○	○
Feeling *distant or cut off* from other people?	○	○	○	○	○
Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	○	○	○	○	○
Feeling as if your *future* will somehow be *cut short*?	○	○	○	○	○
Trouble *falling* or *staying asleep*?	○	○	○	○	○
Feeling *irritable* or having *angry outbursts*?	○	○	○	○	○
Having *difficulty concentrating*?	○	○	○	○	○
Being "*super alert*" or watchful on guard?	○	○	○	○	○
Feeling *jumpy* or easily startled?	○	○	○	○	○

Section 9: Gastrointestinal Symptoms

In the last 3 months, how often did you have discomfort or pain anywhere in your abdomen? (Fill in one answer.)

Never	Less than one day a month	One day a month	Two to three days a month	One day a week	More than one day a week	Every day
○	○	○	○	○	○	○

If you answered **NEVER** to the previous question, please skip to Section 10.
If you selected **ANY OTHER ANSWER**, please continue to answer the following questions:

FOR WOMEN: Did this discomfort or pain occur only during your menstrual bleeding and not at other times? (Fill in one answer.)

○ No ○ Yes ○ Does not apply

Have you had this discomfort or pain 6 months or longer? (Fill in one answer.)

○ No ○ Yes

	NEVER OR RARELY	SOMETIMES	OFTEN	MOST OF THE TIME	ALWAYS
How often did this discomfort or pain get better or stop after you had a bowel movement?	○	○	○	○	○
When this discomfort or pain started, did you have more frequent bowel movements?	○	○	○	○	○
When this discomfort or pain started, did you have less frequent bowel movements?	○	○	○	○	○
When this discomfort or pain started, were your stools (bowel movements) looser?	○	○	○	○	○
When this discomfort or pain started, how often did you have harder stools?	○	○	○	○	○
In the last 3 months, how often did you have hard or lumpy stools?	○	○	○	○	○
In the last 3 months, how often did you have loose, mushy, or watery stools?	○	○	○	○	○

Section 10: Pain and Fatigue

1. On a scale of 0 to 10 with 0 being no pain and 10 being the worst pain imaginable (Fill in one answer for each item.):

	0	1	2	3	4	5	6	7	8	9	10
How would you rate your pain **RIGHT NOW**?	○	○	○	○	○	○	○	○	○	○	○
How would you rate your **USUAL** level of pain during last week?	○	○	○	○	○	○	○	○	○	○	○
How would you rate your **BEST** level of pain during last week?	○	○	○	○	○	○	○	○	○	○	○
How would you rate your **WORST** level of pain during last week?	○	○	○	○	○	○	○	○	○	○	○

2. Over the last 3 months, have you had pain lasting at least 1 week in any of the areas outlined below? (Fill in one answer for each item.)

	NO	YES		NO	YES
Left shoulder	○	○	Left lower leg	○	○
Right shoulder	○	○	Right lower leg	○	○
Left upper arm	○	○	Left jaw	○	○
Right upper arm	○	○	Right jaw	○	○
Left lower arm	○	○	Chest	○	○
Right lower arm	○	○	Abdomen	○	○
Left hip	○	○	Upper back	○	○
Right hip	○	○	Lower back	○	○
Left upper leg	○	○	Neck	○	○
Right upper leg	○	○			

3. If you have checked any of the above locations, has this pain lasted for more than **3 MONTHS**? (Fill in one answer.)

○ No ○ Yes

4. Please describe, during the **PAST MONTH**, how often you have the following symptoms. If you have them, please **ALSO** specify the intensity of each symptom and if it has been present for 6 months or more.
(Fill in one answer for each category of each item.)

	FREQUENCY					INTENSITY			PRESENT FOR 6 MONTHS OR MORE	
	Never	A little of the time	Some of the time	Most of the time	All of the time	Mild	Moderate	Severe	No	Yes
Prolonged fatigue or a feeling of illness, lasting longer than a day, after mild exercise	○	○	○	○	○	○	○	○	○	○
Unrefreshing sleep	○	○	○	○	○	○	○	○	○	○
Substantial problems remembering	○	○	○	○	○	○	○	○	○	○
Substantial problems concentrating	○	○	○	○	○	○	○	○	○	○
Muscle discomfort or pains/aches	○	○	○	○	○	○	○	○	○	○
Pain in joints such as elbows, knees and fingers, without redness or swelling	○	○	○	○	○	○	○	○	○	○
Sore throat	○	○	○	○	○	○	○	○	○	○
Tender glands in neck, jaw, or armpits	○	○	○	○	○	○	○	○	○	○
New types of headaches	○	○	○	○	○	○	○	○	○	○
Diarrhea	○	○	○	○	○	○	○	○	○	○
Feeling feverish	○	○	○	○	○	○	○	○	○	○
Chills	○	○	○	○	○	○	○	○	○	○
Sleeping problems	○	○	○	○	○	○	○	○	○	○
Nausea	○	○	○	○	○	○	○	○	○	○
Stomach or abdominal pain	○	○	○	○	○	○	○	○	○	○
Sinus or nasal problems	○	○	○	○	○	○	○	○	○	○
Shortness of breath	○	○	○	○	○	○	○	○	○	○
Sensitivity to light	○	○	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○	○	○

5. To what degree has your fatigue limited your daily activity **OVER THE PAST 6 MONTHS**?

○	○	○	○	○	○	○
0% normal overall activity: no limitations	1%-25%	26%-49%	50% activity level reduced to 50% of normal	51%-75%	76%-99%	100% totally disabled bedridden constantly

Section 11: Headaches

1. Do you experience migraine headaches? (Fill in one answer.) ○ No ○ Yes

! If you answered **NO** to the previous question, please skip to Section 12.
If you answered **YES**, please continue to Question 2:

2. These questions are designed to help us understand the effects of migraine headaches on your daily activities. Please fill in only **ONE** answer for each question. While answering the following questions, please think about all migraine attacks you may have had in the **PAST 4 WEEKS** (Fill in one answer for each item.):

	NEVER	A LITTLE OF THE TIME	SOME OF THE TIME	A GOOD BIT OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
How often have migraines interfered with how well you dealt with family, friends, and others who are close to you?	○	○	○	○	○	○
How often have migraines interfered with your leisure time activities, such as reading or exercising?	○	○	○	○	○	○
How often have you had difficulty in performing work or daily activities because of migraine symptoms?	○	○	○	○	○	○
How often did migraines keep you from getting as much done at work or home?	○	○	○	○	○	○
How often did migraines limit your ability to concentrate on work or daily activities?	○	○	○	○	○	○
How often have migraines left you too tired to do work or daily activities?	○	○	○	○	○	○
How often have migraines limited the number of days you have felt energetic?	○	○	○	○	○	○
How often have you had to cancel work or daily activities because you had a migraine?	○	○	○	○	○	○
How often did you need help in handling routine tasks such as every day household chores, doing necessary business, shopping, or caring for others when you had a migraine?	○	○	○	○	○	○
How often did you have to stop work or daily activities to deal with migraine symptoms?	○	○	○	○	○	○
How often were you not able to go to social activities, such as parties and dinner with friends, because you had a migraine?	○	○	○	○	○	○
How often have you felt fed up or frustrated because of your migraines?	○	○	○	○	○	○
How often have you felt like you were a burden on others because of your migraines?	○	○	○	○	○	○
How often have you been afraid of letting others down because of your migraines?	○	○	○	○	○	○

Section 12: Sleep

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

BED TIME (24 HOUR FORMAT): ☐☐ : ☐☐ (H H : M M)

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES: ☐☐☐☐

3. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME (24 HOUR FORMAT): ☐☐ : ☐☐ (H H : M M)

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOUR OF SLEEP PER NIGHT: ☐☐

For each of the remaining questions, fill in one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you...

	NOT DURING THE PAST MONTH	LESS THAN ONCE A WEEK	ONCE OR TWICE A WEEK	THREE OR MORE TIMES A WEEK
Cannot get to sleep within 30 minutes	○	○	○	○
Wake up in the middle of the night or early morning	○	○	○	○
Have to get up to use the bathroom	○	○	○	○
Cannot breathe comfortably	○	○	○	○
Cough or snore loudly	○	○	○	○
Feel too cold	○	○	○	○
Feel too hot	○	○	○	○
Had bad dreams	○	○	○	○
Have pain	○	○	○	○
Other reason(s)...	○	○	○	○

Please describe other reason(s): _____

_____

_____

6. During the past month, how would you rate your sleep quality overall? (Fill in one answer.)

Very good	Fairly Good	Fairly Bad	Very Bad
○	○	○	○

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")? (Fill in one answer.)

Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
○	○	○	○

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity? (Fill in one answer.)

Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
○	○	○	○

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done? (Fill in one answer.)

No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
○	○	○	○

10. Do you have a bed partner or roommate? (Fill in one answer.)

No bed partner or roommate	Partner/roommate in other room	Partner in same room, but not same bed	Partner in same bed
○	○	○	○

! If you have a roommate or bed partner, ask him/her how often in the past month you have had... (Fill in one answer for each item.)

	NOT DURING THE PAST MONTH	LESS THAN ONCE A WEEK	ONCE OR TWICE A WEEK	THREE OR MORE TIMES A WEEK
Loud snoring	○	○	○	○
Long pauses between breaths while asleep	○	○	○	○
Legs twitching or jerking while you sleep	○	○	○	○
Episodes of disorientation or confusion during sleep	○	○	○	○
Other restlessness while you sleep...	○	○	○	○

Please describe: _____

_____

_____

Section 13A: Military Environmental Exposures

For each of the following potential deployment and military service related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

THE **FREQUENCY** OF THE EXPOSURE		THE **INTENSITY** OF THE EXPOSURE		THE AMOUNT OF YOUR **CONCERN**	
1	**Seldom** to few days while deployed	1	**No** noticeable health effects	1	**Not** concerned
2	**Occasionally** to about half of deployment	2	**Mild** effects or symptoms that **did not affect ability** to conduct physical activities. Examples: mild eye or throat irritation, strange odors.	2	**Moderately** concerned
3	**Majority** of days during deployment	3	**Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3	**Very** concerned
4	**Every day** while deployed	4	**Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.		

Have you been exposed to (Fill in one answer.)…

Agent Orange or other herbicides? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Animal bites? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Animal Bodies? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Anthrax Vaccine? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Asbestos? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Biological warfare agents? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

For each of the following potential deployment and military service related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

THE **FREQUENCY** OF THE EXPOSURE		THE **INTENSITY** OF THE EXPOSURE		THE AMOUNT OF YOUR **CONCERN**	
1	**Seldom** to few days while deployed	1	**No** noticeable health effects	1	**Not** concerned
2	**Occasionally** to about half of deployment	2	**Mild** effects or symptoms that **did not affect ability** to conduct physical activities. Examples: mild eye or throat irritation, strange odors.	2	**Moderately** concerned
3	**Majority** of days during deployment	3	**Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3	**Very** concerned
4	**Every day** while deployed	4	**Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.		

Have you been exposed to (Fill in one answer for each category.)…

Chemical alarms/MOPP 4?..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Chemical nerve agent antidotes (pyridostigmine bromide or NAPP)?..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Chemical weapons (nerve agents, sarin, blistering agents, etc.)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Chemicals (solvents, cleaners, degreasers, etc.)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Chlorine gas?..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Ingestion of contaminated water? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

For each of the following potential deployment and military service related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

THE **FREQUENCY** OF THE EXPOSURE		THE **INTENSITY** OF THE EXPOSURE		THE AMOUNT OF YOUR **CONCERN**	
1	**Seldom** to few days while deployed	1	**No** noticeable health effects	1	**Not** concerned
2	**Occasionally** to about half of deployment	2	**Mild** effects or symptoms that **did not affect ability** to conduct physical activities. Examples: mild eye or throat irritation, strange odors.	2	**Moderately** concerned
3	**Majority** of days during deployment	3	**Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3	**Very** concerned
4	**Every day** while deployed	4	**Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.		

Have you been exposed to (Fill in one answer for each category.)…

Bathed or washed in contaminated water? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Excessive vibration? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Fog oils (smoke screen)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Human blood, body fluids? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Industrial air pollution (e.g., from factories)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Infectious disease (i.e., skin, stomach, respiratory, etc.)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

For each of the following potential deployment and military service related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

THE **FREQUENCY** OF THE EXPOSURE		THE **INTENSITY** OF THE EXPOSURE		THE AMOUNT OF YOUR **CONCERN**	
1	**Seldom** to few days while deployed	1	**No** noticeable health effects	1	**Not** concerned
2	**Occasionally** to about half of deployment	2	**Mild** effects or symptoms that **did not affect ability** to conduct physical activities. Examples: mild eye or throat irritation, strange odors.	2	**Moderately** concerned
3	**Majority** of days during deployment	3	**Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3	**Very** concerned
4	**Every day** while deployed	4	**Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.		

Have you been exposed to (Fill in one answer for each category.)…

Insect bites? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Insecticides, pesticides, flea collars? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Ionizing radiation or radiological agents? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Lasers? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Loud noises? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Paint/Painting operations (vehicles or equipment) or exposed to Peeling Paint? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

For each of the following potential deployment and military service related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

THE **FREQUENCY** OF THE EXPOSURE		THE **INTENSITY** OF THE EXPOSURE		THE AMOUNT OF YOUR **CONCERN**	
1	**Seldom** to few days while deployed	1	**No** noticeable health effects	1	**Not** concerned
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3	**Majority** of days during deployment	3	**Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3	**Very** concerned
4	**Every day** while deployed	4	**Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.		

Have you been exposed to (Fill in one answer for each category.)…

Petrochemical fuels or fumes (vehicle exhaust)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Weapons' exhaust within an enclosed space? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Prophylactic meds (antimalarials, antibiotics)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Radar/Microwaves? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Sand/Dust? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Smoke from burning trash or feces? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

For each of the following potential deployment and military service related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

THE **FREQUENCY** OF THE EXPOSURE		THE **INTENSITY** OF THE EXPOSURE		THE AMOUNT OF YOUR **CONCERN**	
1	**Seldom** to few days while deployed	1	**No** noticeable health effects	1	**Not** concerned
2	**Occasionally** to about half of deployment	2	**Mild** effects or symptoms that **did not affect ability** to conduct physical activities. Examples: mild eye or throat irritation, strange odors.	2	**Moderately** concerned
3	**Majority** of days during deployment	3	**Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3	**Very** concerned
4	**Every day** while deployed	4	**Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.		

Have you been exposed to (Fill in one answer for each category.)…

Smoke from oil fire? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Tent heater smoke? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Vaccinations (small pox, yellow fever, hepatitis A/B, etc.)? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Depleted Uranium? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Embedded metal fragments? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:

THE **FREQUENCY**				THE **INTENSITY**				YOUR **CONCERN**		
○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Other comments: _____

_____

_____

_____

Section 13B: Military Environmental Exposures

1. While in the military, were you monitored or assessed as part of any occupational health program? (Fill in one answer.)

   ○ No ○ Yes

   If you answered **NO** to the previous question, please skip to Question 2.
   If you answered **YES**, please continue to Question 1a:

   a. Please indicate which programs (Fill in all that apply):

   ☐ Respiratory Protection Program ☐ Medical Surveillance Program ☐ Asbestos Surveillance Program

   ☐ Other/Comment: _____

   _____

2. While deployed, how many days did you wear an N95 or other respirator or an M40 or other mask?

   Number of days: ☐☐☐

   If you entered **"0"** days to the previous question, please skip to Question 3.
   If you answered **ANYTHING ELSE**, please continue to Question 2a:

   If worn, please describe the type(s) of respirator(s)/mask(s), associated job duty (duties), and duration(s) worn:

   _____

   _____

   _____

   _____

   _____

   _____

3. While deployed, how often did you wear a cravat (large kerchief-type cloths) to minimize air exposures?

   Number of days: ☐☐☐

4. While deployed, how many days was the air quality so bad that it was a "no fly day" and/or most outdoor missions were halted due to lack of visibility?

   Number of days: ☐☐☐

5. Please indicate if any of the following events occurred during your military service. If any of these occurred, please describe the health condition(s) associated with the event and the date it occurred.

EVENT	HEALTH CONDITION(S)	DATES (MONTH/YEAR)
Hospitalization		MM / YYYY
Evacuation out of area of operation		MM / YYYY
Temporary profile with duty limitations		MM / YYYY
Limitation of your duties by your commander		MM / YYYY
Change of MOS/assigned occupational series		MM / YYYY
Medically boarded out of service		MM / YYYY

Section 14: Civilian Environmental Exposures

For each of the following potential **NON-MILITARY, WORK/HOBBY** related exposures, please tell us which, if any, you have been exposed to. Of those things that you have been exposed to, please tell us about:

YEARS OF EXPOSURE	THE **INTENSITY** OF THE EXPOSURE	THE AMOUNT OF YOUR **CONCERN**
1 **5** years or less	1 **No** noticeable health effects	1 **Not** concerned
2 **6-10** years	2 **Mild** effects or symptoms that **did not affect ability** to conduct physical activities. Examples: mild eye or throat irritation, strange odors.	2 **Moderately** concerned
3 **11-15** years	3 **Moderate** effects or symptoms that had **some effect** on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea.	3 **Very** concerned
4 **16-20** years	4 **Severe** effects to include those described above but that were so debilitating, they **severely impaired** physical activity and/or required **medical treatment**.	
5 **21+** years		

Have you been exposed to (Fill in one answer for each category.)…

Dust from baking flours, grains, wood, cotton, plants, or animals? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**					THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Dust from rock, sand, concrete, coal, asbestos, silica, or soil? ..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**					THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Chemical gases or vapors (e.g., from paints, cleaning products, glues, solvents, and acids)? .. ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**					THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Metal fumes (e.g., welding/soldering fumes)?..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**					THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Exhaust fumes (e.g., from trucks, buses, heavy machinery, or diesel engines)?..... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**					THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Other (Please describe.): _____?.... ○ No ○ Yes ○ Don't Know

If you answered **YES**, please tell us about:	THE **FREQUENCY**					THE **INTENSITY**				YOUR **CONCERN**		
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 1	○ 2	○ 3	○ 4	○ 1	○ 2	○ 3

Have you had to wear respiratory protection for any of your civilian jobs? (e.g., firefighter). (Fill in one answer.)

○ No ○ Yes

If **YES**, please describe: _____

_____

_____

_____

_____

_____

_____

Did any of these civilian exposures require medical treatment or evaluation? (Fill in one answer.)

○ No ○ Yes

If **YES**, please describe: _____

_____

_____

_____

_____

_____

_____

Have you ever been put on a work restriction or received disability for any of these civilian exposures? (Fill in one answer.)

○ No ○ Yes

If **YES**, please describe: _____

_____

_____

_____

_____

_____

_____

Section 15: Military Deployments

1. Did you ever go on combat patrols or have other very dangerous duties? If so, please estimate the number of times this occurred. (Fill in one answer.)

O No O 1-3 times O 4-12 times O 13-50 times O 51 or more times

2. Were you ever under enemy fire during your deployment(s)? If so, please estimate length of time. (Fill in one answer.)

O Never O Less than a month O 1-3 months O 4-6 months O 7 months or more

3. Were you ever surrounded by the enemy? If so, please indicate how often. (Fill in one answer.)

O No O 1-2 times O 3-12 times O 13-25 times O 26 or more times

4. What percentage of the people in your unit were killed, wounded, or missing in action? (Fill in one answer.)

O None O 1-25% O 26-50% O 51-75% O 76% or more

5. How often did you fire rounds at the enemy? (Fill in one answer.)

O Never O 1-2 times O 3-12 times O 13-50 times O 51 or more times

6. How often did you see someone hit by incoming or outgoing rounds? (Fill in one answer.)

O Never O 1-2 times O 3-12 times O 13-50 times O 51 or more times

7. How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)? (Fill in one answer.)

O Never O 1-2 times O 3-12 times O 13-50 times O 51 or more times

8. During your deployment(s), were you wounded, injured, assaulted or otherwise physically hurt? (Fill in one answer.)

O No O Yes O Unsure

9. If you were wounded, injured, assaulted or otherwise physically hurt, are you still having problems related to this wound, assault or injury? (Fill in one answer.)

O No O Yes O Unsure O Not Applicable

10. Did you seek or receive medical attention during your deployment(s)? (Fill in one answer.)

O No O Yes

If you answered **YES,** to the previous question, please describe: _____

_____

11. Since you returned from deployment(s), about how many times have you seen a healthcare provider for any reason, such as sick call, emergency room, primary care, family doctor or mental health provider? (Fill in one answer.)

O No visits O 2-4 visits O 5-9 visits O 10-14 visits O 15-20 visits O 21-25 visits O 26-30 visits O More than 30 visits

Section 16: Unit Cohesion

The statements below are about your relationships with other military personnel while you were deployed. Please read each statement and describe how much you agree or disagree by filling in one answer for each item.:

	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE NOR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE
My unit was like family to me.	○	○	○	○	○
I felt a sense of camaraderie between myself and other soldiers in my unit.	○	○	○	○	○
Members of my unit understood me.	○	○	○	○	○
Most people in my unit were trustworthy.	○	○	○	○	○
I could go to most people in my unit for help when I had a personal problem.	○	○	○	○	○
My commanding officer(s) were interested in what I thought and how I felt about things.	○	○	○	○	○
I was impressed by the quality of leadership in my unit.	○	○	○	○	○
My superiors made a real attempt to treat me as a person.	○	○	○	○	○
The commanding officer(s) in my unit were supportive of my efforts.	○	○	○	○	○
I felt like my efforts really counted to the military.	○	○	○	○	○
The military appreciated my service.	○	○	○	○	○
I was supported by the military.	○	○	○	○	○

Section 17: Health Screenings

1. In the **PAST 12 MONTHS**, how often did you have a drink containing alcohol? (Fill in one answer.)

O Never O Monthly or less O 2-4 times a month O 2-3 times per week O 4 or more times per week

2. In the **PAST 12 MONTHS**, how many drinks containing alcohol did you have on a typical day that you drank? (Fill in one answer.)

O 0 O 1-2 O 3-4 O 5-6 O 7-9 O 10 or more

3. In the **PAST 12 MONTHS**, how often did you have six or more drinks on one occasion? (Fill in one answer.)

O Never O Less than monthly O Monthly O Weekly O Daily or almost daily

4. Do you now use or have you used any of the below substances in the past? (Fill in one answer per item.)

	NEVER	IN THE PAST	PRESENTLY
Caffeine	O	O	O
Cigarettes	O	O	O
Chewing tobacco/Snuff	O	O	O
Marijuana	O	O	O
Beer/Alcohol	O	O	O
Amphetamines (e.g., methamphetamines)	O	O	O
Cocaine or crack	O	O	O
Hallucinogenics (LSD, acid, etc.)	O	O	O
Inhalants (glue, nitrous oxide, etc.)	O	O	O
Heroin	O	O	O
PCP (or "angel dust")	O	O	O
Bath salts	O	O	O
Prescription drugs to the point of abuse	O	O	O
Other...	O	O	O

Please describe: _____

_____

_____

5. Did you grow up in a household with a smoker? (Fill in one answer.) O No O Yes

6. Are you living in a household with a smoker? (Fill in one answer.) O No O Yes

7. During any of your deployments, did you experience any of the following events? (Fill in one answer for each item.)

	NO	YES
Blast or explosion (IED, RPG, land mine, grenade, etc.)	○	○
Vehicular accident/crash (any vehicle including aircraft)	○	○
Fragment wound or bullet wound above your shoulders	○	○
Fall	○	○
Blow to head (sports injury, hit head against something)	○	○

Other injury to head: _____

_____

IMPORTANT: If you answered **YES TO ANY** of the items in Question 7, please answer Question 8.
Otherwise, skip to Question 11.

8. When you experienced any of the events above (in Question 7), did you have any of these symptoms **IMMEDIATELY** afterwards? (Fill in one answer for each item.)

	NO	YES
Losing consciousness/"knocked out"	○	○
Being dazed, confused, or "seeing stars"	○	○
Not remembering the event	○	○
Told you had a concussion	○	○
Head injury (visible wound)	○	○

IMPORTANT: If you answered **YES TO ANY** items in Question 8, please continue to Question 9.
If you answered **NO TO ALL** items in Question 8 above, then please skip to Question 11.

9. When you experienced any of the events above (in Question 7), did any of the following problems begin or get worse afterwards? (Fill in one answer for each item.)

	NO	YES
Memory problems or lapses	○	○
Balance problems or dizziness	○	○
Sensitivity to bright light	○	○
Irritability	○	○
Headaches	○	○
Sleep problems	○	○

IMPORTANT: If you answered **YES TO ANY** items in Question 9, please continue to Question 10.
If you answered **NO TO ALL** items in Question 9 above, then please skip to Question 11.

10. When you experienced any of the events above (in Question 7) during the **PAST WEEK**, have you had any of the following symptoms? (Fill in one answer for each item.)

	NO	YES
Memory problems or lapses	○	○
Balance problems or dizziness	○	○
Sensitivity to bright light	○	○
Irritability	○	○
Head aches	○	○
Sleep problems	○	○

11. Other than during your deployment(s), have you ever experienced an event that resulted in your being dazed, losing consciousness, or being unable to remember the event? (Fill in one answer.)

O No O Yes

If you answered **YES**, please describe the event(s): _____

Section 18: WRIISC Program

How did you hear about the WRIISC program? (Fill in all that apply.)

- ☐ VA health care provider
- ☐ Non-VA health care provider
- ☐ Fellow Veteran
- ☐ Vet Center Provider/Personnel
- ☐ OEF/OIF/OND coordinator
- ☐ Veteran Service Organization
- ☐ Military person or event
- ☐ Flyer, brochure or advertisement...

Please specify: _____

- ☐ Web site...

Please specify: _____

- ☐ Other...

Please specify: _____

In thinking about the reasons for your visit, how important are each of the following reasons (Fill in one answer per item.):

	NOT AT ALL	A LITTLE	A LOT
Understand the cause of my symptoms	○	○	○
Reduce my symptoms even if I don't have an explanation	○	○	○
Understand what effect war-related exposures may have had	○	○	○
Obtain a complete examination	○	○	○
Obtain a mental health evaluation	○	○	○
Make it easier for other people like me to get help	○	○	○

The following is a list of sources that people sometimes use to obtain health information. For each source, please indicate how much health information you typically get from the source (Fill in one answer per item.):

	NONE AT ALL	A LITTLE	A LOT
Newspaper/Magazines	○	○	○
Friends/Family	○	○	○
VA/DOD health care professionals	○	○	○
Non-VA/DOD health care professionals	○	○	○
Television	○	○	○
Web sites	○	○	○
Support groups	○	○	○
Social Media (i.e. Facebook, Twitter, Linked-in)	○	○	○
Other...	○	○	○

Please describe: _____

_____

Section 19: Somatic Symptom Severity

During the past 4 weeks, how much have you been bothered by any of the following problems? (Fill in one answer per item.)

	NOT BOTHERED AT ALL	BOTHERED A LITTLE	BOTHERED A LOT
Stomach pain	○	○	○
Back pain	○	○	○
Pain in your arms, legs, or joints (knees, hips, etc.)	○	○	○
Menstrual cramps or other problems with your periods (Women only)	○	○	○
Headaches	○	○	○
Chest pain	○	○	○
Dizziness	○	○	○
Fainting spells	○	○	○
Feeling your heart pound or race	○	○	○
Shortness of breath	○	○	○
Pain or problems during sexual intercourse	○	○	○
Constipation, loose bowels, or diarrhea	○	○	○
Nausea, gas, or indigestion	○	○	○
Feeling tired or having low energy	○	○	○
Trouble sleeping	○	○	○

Section 20: OEF/OIF/OND Information

IMPORTANT: This section is for Veterans who have served in Operation Enduring Freedom, Operation Iraqi Freedom, and/or Operation New Dawn (OEF/OIF/OND).

1. Did you serve in Iraq or Afghanistan, left on the ground, or in nearby coastal waters, or in the air, after September 11, 2001? (Fill in one answer.)

   ○ No ○ Yes

2. Do you have any problems with chronic diarrhea or other gastrointestinal complaints since serving in the area of conflict? (Fill in one answer.)

   ○ No ○ Yes

3. Do you have a popular or nodular (bumpy) skin rash that began after your deployment? (Fill in one answer.)

   ○ No ○ Yes

4. Do you have any unexplained fevers? (Fill in one answer.)

   ○ No ○ Yes

5. Do you have or suspect that you have retained fragments or shrapnel as a result of injuries while serving in the area of conflict? (Fill in one answer.)

   ○ No ○ Yes

Section 21: Tobacco Use

!IMPORTANT: This section is for Veterans who currently smoke tobacco or have smoked tobacco in the past.

1. Have you smoked more than 100 cigarettes or 20 cigars or 20 ounces of pipe tobacco in your lifetime? (Fill in one answer.)

   ○ No ○ Yes

! If you answered **NO** to the previous question, you are finished. **DO NOT** complete the rest of this section.
If you answered **YES**, please continue to Question 2:

2. Over the entire time you smoked, indicate the amount that best represents the average number that you smoked for each type of product used (Fill in one answer for each item.):

CIGARETTES	CIGARS	PIPE/TOBACCO
○ 0 (none)	○ 0 (none)	○ 0 (none)
○ 1-2 a day/intermittent/occasional	○ Less than 7 per week	○ Less than 7 per week
○ 3-10 (up to half a pack) a day	○ 7-14 per week	○ 7-14 per week
○ 11-20 (up to a pack) a day	○ More than 14 per week	○ More than 14 per week
○ 21-40 (1-2 packs) a day		
○ More than 40 cigarettes (more than 2 packs) a day		

3. How old were you when you started smoking regularly? ☐☐ years old

4. a. Do you still smoke? (Fill in one answer.)

   ○ No ○ Yes

! If you answered **NO** to the previous question, how old were you when you stopped? ☐☐☐ years old
If you answered **YES**, please continue to Question 4b:

b. If you have quit, why did you stop? (Fill in one answer.)

○ Personal decision

○ Medical condition...

Please describe: _____

_____

_____

_____

_____

Thank you for taking the time to fill out this WRIISC Health Questionnaire.

This survey has been adapted from a variety of health care surveys.
If you would like more information or have any questions, please ask a WRIISC staff member.

Cognitive and Behavioral Health

First Name: Last Name:

SSN: - -

Please rate the following symptoms with regard to how much they have disturbed you in the **LAST 2 WEEKS**. (Fill in one answer for each item.)

NONE	Rarely if ever present; not a problem at all
MILD	Occasionally present, but it does not disrupt my activities; I can usually continue what I'm doing; doesn't really concern me
MODERATE	Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.
SEVERE	Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel I need help.
VERY SEVERE	Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Feeling Dizzy	○	○	○	○	○
Loss of balance	○	○	○	○	○
Poor coordination, clumsy	○	○	○	○	○
Headaches	○	○	○	○	○
Nausea	○	○	○	○	○
Vision problems, blurring, trouble seeing	○	○	○	○	○
Sensitivity to light	○	○	○	○	○
Hearing difficulty	○	○	○	○	○
Sensitivity to noise	○	○	○	○	○
Numbness or tingling on parts of my body	○	○	○	○	○
Change in taste and/or smell	○	○	○	○	○
Loss of appetite or increased appetite	○	○	○	○	○
Poor concentration, can't pay attention, easily distracted	○	○	○	○	○
Forgetfulness, can't remember things	○	○	○	○	○
Difficulty making decisions	○	○	○	○	○
Slowed thinking, difficulty getting organized, can't finish things	○	○	○	○	○
Fatigue, loss of energy, getting tired easily	○	○	○	○	○
Difficulty falling or staying asleep	○	○	○	○	○
Feeling anxious or tense	○	○	○	○	○
Feeling depressed or sad	○	○	○	○	○
Irritability, easily annoyed	○	○	○	○	○
Poor frustration tolerance, feeling easily overwhelmed by things	○	○	○	○	○

Below are statements describing everyday inefficiencies, lapses of attention or memory, and related functions that people often notice about themselves. Please rate the degree to which each statement describes your typical or usual behavior during the **PAST 2 WEEKS**. (Fill in one answer for each item.)

	NEVER	RARELY	SOMETIMES	OFTEN	VERY OFTEN
When interrupted while reading, I have trouble finding my place again	○	○	○	○	○
I need a written list when I do errands	○	○	○	○	○
I forget appointments, dates, or meetings	○	○	○	○	○
I forget to return phone calls	○	○	○	○	○
I have trouble getting my keys into a lock	○	○	○	○	○
I forget errands I planned to do	○	○	○	○	○
I have trouble recalling names of people I know	○	○	○	○	○
I find it hard to keep my mind on a task or a job	○	○	○	○	○
I have trouble describing a program I have just watched on television	○	○	○	○	○
I have trouble expressing what I mean to say	○	○	○	○	○
I fail to recognize people I know	○	○	○	○	○
I have trouble getting out a word that's on the tip of my tongue	○	○	○	○	○
I find it hard to understand what I read	○	○	○	○	○
I forget names of people soon after being introduced	○	○	○	○	○
I lose my train of thought when I listen to somebody else	○	○	○	○	○
I forget what day of the week it is	○	○	○	○	○
I make mistakes in writing or calculating	○	○	○	○	○
I cannot keep my mind on one thing	○	○	○	○	○
I have trouble manipulating buttons or zips	○	○	○	○	○
I have trouble sewing, mending, making minor household repairs	○	○	○	○	○
I have trouble fixing my mind on what I'm reading	○	○	○	○	○
I forget right away what people say to me	○	○	○	○	○
I forget to pay bills, record cheques, or mail letters	○	○	○	○	○
My mind just goes blank at times	○	○	○	○	○
I forget the date of the month	○	○	○	○	○
I have trouble manipulating tools, scissors, corkscrews or can-openers	○	○	○	○	○